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Integrated Health Home Workgroup Meeting February 16, 2022

February 16, 2022

Introductions

Format of Workgroup

- Discuss prior meeting (high level)
- Topic for the meeting
- Plan and expectations for next meeting

It is ok to ask questions during the meeting and between meetings. These questions and answers will be shared at the beginning of each meeting.

What is Our Why? What Do We Want to Accomplish?

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Ground Rules

- You can respect another person's point of view without agreeing with them.
- Respectfully challenge the idea, not the person and bring potential solutions.
- Blame or judgment will get you further from a solution, not closer.
- Honest and constructive discussions are necessary to get the best results.
- Listen respectfully, without interrupting.
- Listen actively and with an ear to understanding others' views. (Don't just think about what you are going to say while someone else is talking.)
- Commit to learning, not debating. Comment in order to share information, not to persuade.
- Avoid blame, speculation, and inflammatory language.
- Allow everyone the chance to speak.

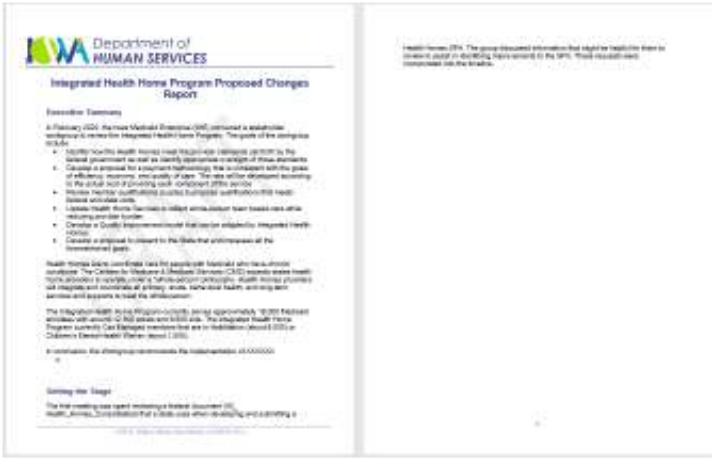
Objectives

- Review of Last Meeting
- Workgroup Report
- Integrated Health Home SPA
  - What are we meeting now?
  - What changes were made and why? (Added, Edited, or deleted)
  - Flow chart of what is the authority (Federal code, Iowa code, SPA…)
  - Include SPA from 2016 as supporting documentation.

Last Meeting

- Reviewed the timeline and plan for the next few months
- Reviewed Federal Guidance for developing a Health Homes State Plan Amendment
- Plan for the next meeting and discussed what may be needed to support the work
- Questions/Answers

Workgroup Report



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Integrated Health Home Program Proposed Changes Report

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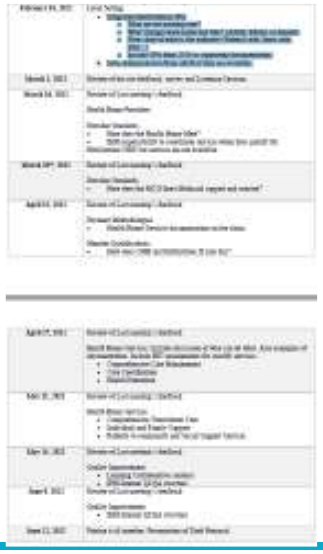
Overview of the Timeline



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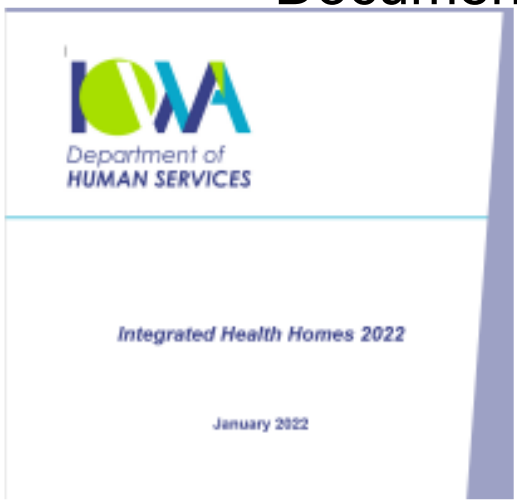
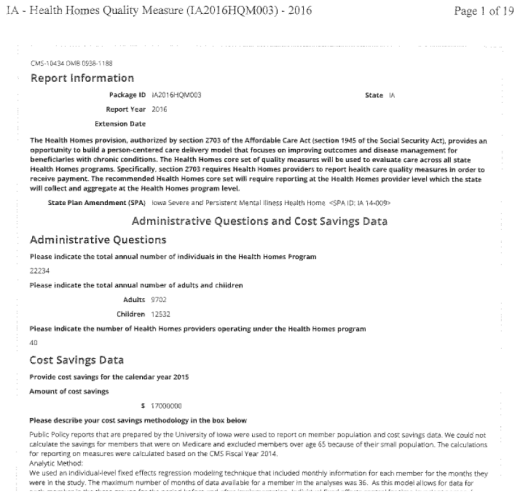
Documents for Today




IA - Health Homes Quality Measure (IA2016HQM003) - 2016 Page 1 of 19

CMS-10434 OMB 0938-1188

Report Information

Package ID IA2016HQM003 **State** IA

Report Year 2016

Extension Date

The Health Homes provision, authorized by section 2703 of the Affordable Care Act (section 1945 of the Social Security Act), provides an opportunity to build a person-centered care delivery model that focuses on improving outcomes and disease management for beneficiaries with chronic conditions. The Health Homes core set of quality measures will be used to evaluate care across all state Health Homes programs. Specifically, section 2703 requires Health Homes providers to report health care quality measures in order to receive payment. The recommended Health Homes core set will require reporting at the Health Homes provider level which the state will collect and aggregate at the Health Homes program level.

State Plan Amendment (SPA) Iowa Severe and Persistent Mental Illness Health Home <SPA ID: IA 14-009>

Administrative Questions and Cost Savings Data

Administrative Questions

Please indicate the total annual number of individuals in the Health Homes Program

22234

Please indicate the total annual number of adults and children

Adults 9702

Children 12532

Please indicate the number of Health Homes providers operating under the Health Homes program

40

Cost Savings Data

Provide cost savings for the calendar year 2015

Amount of cost savings

$ 17000000

Please describe your cost savings methodology in the box below

Public Policy reports that are prepared by the University of Iowa were used to report on member population and cost savings data. We could not calculate the savings for members that were on Medicare and excluded members over age 65 because of their small population. The calculations for reporting on measures were calculated based on the CMS Fiscal Year 2014.

Analytic Method:

We used an individual-level fixed effects regression modeling technique that included monthly information for each member for the months they were in the study. The maximum number of months of data available for a member in the analyses was 36. As this model allows for data for

Why the Red/Black and Bolded in the Upcoming Slides?

- Red means it has changed from 2016. It could be that it was in the prior SPA in a different place, clarification of a requirement in 2016, or an addition/change.
- Black means it is the same exact language in the same place in the 2016 SPA.
- Bolded means it isn't fully implemented.

Population Criteria

One or More Serious and Persistent Mental Health Condition (IA-22-0004-IHH, 2022)

- Serious Mental Illness or Serious Emotional Disturbance verified (within the last year)
  - Persistent or chronic mental, behavioral, emotional disorder
  - Causes serious functional impairment and substantially interferes with or limits one or more major life activities including functioning in the family, school, employment or community
  - Must be documented by a Licensed Mental Health Professional
- For children three years or younger, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised (DC: 03R) may be used as the diagnostic tool. For children four years and older, the Diagnostic Interview Schedule for Children (DISC) may be used as an alternative to the most current DSM

Serious Mental Illness https://www.samhsa.gov/find-help/disorders
SPMI https://www.legis.iowa.gov/docs/iac/rule/441.25.1.pdf
Chronic Mental Illness https://www.legis.iowa.gov/docs/ACO/chapter/441.24.pdf
Definition of Licensed Mental Health Professional
https://www.legis.iowa.gov/docs/ico/section/228.1.pdf

One or More Serious and Persistent Mental Health Condition (IA-16-013, 2016)

SMI

Psychotic Disorders	Schizophrenia
Schizoaffective Disorder	Major Depression
Bipolar Disorder	Delusional Disorder
Obsessive Compulsive Disorder	

- Exceptions through a prior authorization process for categories above when the behavioral health conditions when the behavioral health condition is chronic functional impairment.

SED

- Mental, behavioral, emotional disorder (DSM) that results in a functional impairment

Functional Impairment

- Difficulties that substantially interfere with or limit the achievement of or maintaining one or more Developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills and substantially Interfere with or limits functioning in family, school, or community activities, difficulties of episodic, recurrent and continuous duration.
- Does not include difficulties resulting from temporary and expected responses to stressful events in a person environment.
- FI will be determined through an assessment provided by the integrated health home that serves children

Enrollment of Participants

Opt-in

- Eligible individuals agree to participate in the Health Home at the initial engagement of the provider in a Health Home Practice.
- A provider presents the qualifying member with the benefits of a Health Home and the member agrees to opt-in to health home services.
- The State or MCO may also identify members for referral to a Health Home.
- In either situation, the member will always be presented with the choice to opt-out at any time.
- A member cannot be in more than one health home at the same time. The State accepts any willing and qualified provider to enroll as a Health Home.
- Members accessing Health Home Services have access to the full range of Medicaid State Plan covered benefits

Red is language that wasn't in 2016. It was a requirement (Federal), but was not spelled out in the prior SPA

Health Home Providers

Team of Health Care Professionals

The Team of Health Care Professionals includes a Lead Entity (when services are delivered via managed care) and a network of qualified IHH providers.

The IHH providers will be qualified and designated by the Lead Entity and IME through a provider agreement.

The majority of Medicaid members are served through the Iowa HealthLink. Each of the Health Homes serving both Fee-For-Service and managed care enrollees receive the support of the Lead Entity.

Red is language that wasn't in 2016. It is adding clarity but doesn't change the requirement.

Composition of the Health Homes Teams

- Physician
  - At least one MD/DO must be part if the Lead Entity
- Nurse Care Coordinator (Nurse Care Manger)
  - The Lead Entity and the IHH must have Nurse Care Manager. RN/BSN with Active License
- Social Worker (Care Coordinator)
  - The Lead Entity and IHH must have Care Coordinator. a Bachelor of Science in Social Work (BSW), or a Bachelor of Science (BS) or Bachelor of Arts (BA) degree in a related field
- Behavioral Health Professional (Psychiatrist)
  - A Psychiatrist must be part of the Lead Entity. must have a MD/DO and hold an active Iowa license and be credentialed

Composition of the Health Homes Teams Cont.

- Other
  - Integrated Health Home
    - (touch on in another section, same in both SPAs)
  - Lead Entity
    - Managed Care Organization
  - Peer Support/Family Peer Support
    - The IHH must have either a Peer Support Specialist or Family Support Specialist. Peer Support Specialists and Family Support Peer Specialists must complete a State recognized training and pass the competency exam within six months of hire if not already trained.

Red language was updated from Parenthesis based on Health Home Provider Feedback 2016 Language (A Peer Support Specialist is a consumer who is in recovery from a Mental illness who has completed 20 hours of training and passed a competency exam based on that Peer Support training. Training domains spelled out.)

Supports for Health Home Providers

Support Health Homes in the 11 core functions

- Program design aligns provider standards and a payment method that ensures that the Health Home Providers have a clear understanding of the expectations and that there is an appropriate reimbursement structure to ensure sustainability for the providers.
- The state expects providers to grow into the role of a successful Health Home and has built-in requirements that the Lead Entity both train and facilitate best practices among the network of IHH providers.
- The State facilitates a Health Home Focus Group comprised of IME, MCO, Health Home personnel and interested stakeholder associations, to ensure training, communication and alignment on key policy and operational issues.
- The State facilitates a Learning Collaborative where Lead Entities will assist IHHs to meet the Provider Standards and to participate in quality improvement activities designed to improve outcomes for the members.
- The State will develop a program manual to provide clear guidance and expectations to both **Lead Entities** and Health Homes

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20

This aligns with the support in the CCHH SPA. Provided more detail as to the expectations of the how.

The Lead Entity Manual Has not been completed yet.

Supports for Health Home Providers

- The state expects providers to grow into the role of a successful Health Home and has built-in requirements that the lead entity both train and facilitate best practices among the network of IHH providers.
- The Lead entity is expected to build capacity among the IHH providers by meeting the following requirements:
  - Identification of providers who meet the standards of participation as an Integrated Health Home;
  - **Assessment of the IHH and physical health provider capacity to provide integrated care**;
  - Educate and support providers to deliver integrated care;
  - **Provide oversight and technical support for IHH providers to coordinate with primary care physical providers participating in the Iowa Medicaid program;**
  - **Provide infrastructure and tools to Behavioral Health IHH providers and primary care physical providers for coordination;**
  - **Provide tools for IHH providers to assess and customize care management based on the physical/behavioral health risk level of recipient;**
  - Perform data analytics on personal, medical, and pharmacy data to identify patterns of care, as well as track, and close gaps in care;
  - **Provide outcomes tools and measurement protocols to assess IHH concept effectiveness;**
  - Provide clinical guidelines and other decision support tools;
  - Repository for member data including claims, laboratory, and Continuing Care Document (CCD) data whenever possible;
  - **Support providers to share data including CCD or other data from electronic medical records (EMR);** and
  - Develop and offer learning activities which will support providers of Integrated Health Home services.

This language is basically Lead Entity Standards and is in both SPAs

Provider Qualifications: Lead Entity

The Lead Entity must be licensed and in good standing in the State of Iowa as a Health maintenance organization (HMO) in accordance with Iowa Administrative Code 191 Chapter 40

Have a statewide integrated network of providers to serve members with SMI/SED

The Lead Entity must complete an annual self-assessment and submit to the State at the time of enrollment

The Lead Entity must meet requirements throughout the state plan amendment

The Lead Entity must participate in monthly, quarterly, and annual outcomes data collection and reporting

Provider Qualifications: IHH

- Be an Iowa accredited Community Mental Health Center or
- Mental Health Service Provider or an Iowa licensed residential group care setting
- Iowa Licensed Psychiatric Medical Institution for Children (PMIC) facility,
- Nationally accredited by the Council on Accreditation (COA),
- The Joint Commission, or Commission on Accreditation of Rehabilitation Facilities (CARF) under the accreditation standards that apply to mental health rehabilitative services

Provider Standards: Lead Entity

- Have the following roles to support the Health Homes
  - Psychiatrist
  - Physician
  - Nurse Care Manager
  - Care Coordinators
- Have capacity to evaluate and select Integrated Health Home providers including:
  - Identification of providers who meet the standards of participation to form an Integrated Health Home
  - **Assessment of the Integrated Health Home and medical health provider's capacity to coordinate integrated care**
  - Educate and support providers to coordinate integrated care
  - Provide oversight, training, and technical support for Integrated Health Home providers to coordinate integrated care
  - **Provide infrastructure and tools to Integrated Health Home providers and primary care physical providers for coordination**

Provider Standards: Lead Entity

- Have capacity to provide clinical and care coordination support to Integrated Health Home providers, including:
  - Confirmation of screening and identification of members eligible for Integrated Health Home Services
  - Provide oversight and support of Integrated Health Home providers to develop care plans and identify care management interventions for Integrated Health Home enrollees
  - Providing or contracting for care coordination, including face-to-face meetings, as necessary to ensure implementation of care plan and appropriate receipt of services
  - Gathering and sharing member-level information regarding health care utilization, gaps in care, and medications
  - Monitor and intervene for Integrated Health Home members who are high need with complex treatment plans
  - Facilitate shared treatment planning meetings for members with complex situations

Provider Standards: Lead Entity

- Have capacity to develop provider information technology infrastructure and provide program tools, including:
  - Providing tools for Integrated Health Home providers to assess and customize care management based on the physical/behavioral health risk level of recipient
  - Performing data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care
  - Providing outcomes tools and measurement protocols to assess Integrated Health Home concept effectiveness
  - Providing clinical guidelines and other decision support tools
  - Repository for member data including claims, laboratory, and Continuing Care Document (CCD) data whenever possible; and
  - Support providers to share data including CCD or other data from electronic health records (EHR)

Provider Standards: Lead Entity

- Have capacity to develop and offer learning activities which will support providers of Integrated Health Home services in addressing the following areas:
  - Providing quality driven, cost effective, culturally appropriate, and person and family driven Health Home Services
  - High quality health care services informed by evidence-based clinical practice guidelines
  - Preventive and health promotion services, including prevention of mental illness and substance use disorders
  - Comprehensive care management, care coordination, and transitional care across settings (transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care)
  - Chronic disease management, including self-management support to members and their families
  - Demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the Health Home Team and individual and family care givers, and provide feedback to practices, as feasible and appropriate
  - Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Provider Standards: IHH

- Provider must be able to provide community-based mental health services to the target population
- Meet the following staff requirements if serving adults:
  - Adult IHH Nurse Care Manager
  - Care Coordinator
  - Trained Peer Support Specialist
- Meet the following staff requirements if serving children:
  - Child IHH Nurse Care Manager
  - Care Coordinator
  - Family Peer Support Specialist

Provider Standards: IHH

Integrated Health Home Provider will have demonstrated capacity to address 11 Health home Core Functions

Recognition/Certification

- Adhere to all federal and state rules and regulations applicable to the Health Home Program including any Recognition and Certification requirements.

Ensure a personal provider for each member

- Ensure each member has an ongoing relationship with a personal provider, physician, nurse practitioner, or physician assistant

Continuity of Care Document (CCD)

- Share CCD records with the State and its Lead Entity (timeline to be approved removed)
- A CCD details all important aspects of the member's medical needs, treatment plan, and medication list
- The CCD shall be updated and maintained by the IHH

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29

Recognition/Certification added to align with the CCHH

Ensure a Personal Provider- The Guide states that you must include input from other key providers including a PCP. Best practice is that every member have a PCP.

CCD - Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum

CCD was also mentioned in Comprehensive Care Management HHS

Provider Standards: IHH

Whole Person Orientation

- Provide or take responsibility for appropriately arranging care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care
- Complete status reports to document member's housing, legal, employment status, education, custody, etc.
- Implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs
- Work with the Lead Entity or IME to develop capacity to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Institutions for Children (PMIC) (Within 3 months removed)
- Have evidence of bi-directional and integrated primary care/behavioral health services through use of a contract, memoranda of agreement or other written agreements approved by the State (Within 6 months removed)
- Provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the IHH on care coordination and hospital/ER notification
- Advocate in the community on behalf of their IHH members as needed

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30

While the first bullet is in red it is just worded different in 2016 SPA Incorporating tools and evidenced based guidelines designed for identifying care opportunities across the age And diagnostic continuum, integrating clinical practices, and coordinating care with other providers.
Aligns with CCHH SPA

Second bulled is reworded
Comprehensive whole person screening conducted for all members using medical and behavioral claims data, medical provider records and patient reporting within 90 days of enrolling. (2016 SPA)

Provider Standards: IHH

Coordinated/Integrated Care

- The Nurse Care Manager or Care Coordinator is responsible for assisting members with medication adherence, appointments, and referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support or lifestyle modification, and behavior change
- Utilize member level information, member profiles, and care coordination plans for high-risk individuals
- Incorporate tools and evidenced-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers
- Conduct interventions as indicated based on the member's level of risk
- Communicate with the member and authorized family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.
- Monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services
- Coordinate or provide access to:
  - Mental healthcare
  - Oral health
  - Long-term care
  - Chronic disease management
  - Recovery services and social health services available in the community
  - Behavior modification interventions aimed at supporting health management (including, but not limited to, obesity counseling, tobacco cessation, and health coaching)
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Crisis services
- Assess social, educational, housing, transportation, and vocational needs that may contribute to disease and present as barriers to self-management
- Coordinate with Community-based Case Managers (CBCM), Case Manager and Service Coordinators for members that receive service coordination activities
- Maintain system and written standards and protocols for tracking member referrals

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31

The first bullet is in the 2016 SPA it is just not together in 1 statement

Medication adherence, understanding Health Insurance coverage, (Health Promotion 2016)

Making referrals, tracking Referrals and scheduling appointments, follow-up monitoring (Care Coordination 2016)

Transition of care (Transitional Care Management 2016) (11 Health Home Core functions)

Wellness education, health support or lifestyle modification, and behavior change (Health Promotion 2016 but isn't stated the same)

Bullet 2 is not directly spelled out like this: Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services (11 Health Home Core functions)

Bullet 3 Preventive and health promotion services, including prevention of mental illness and substance use disorders; (2016)

Bullet 4 (11 Health Home Core functions)

Bullet 5 Transitional Care Management (2016)

Bullet 6 Referral to community and social support services (2016)

Bullet 7 Was in the CCHH SPA, requirement needed to be added to IHH for alignment

Bullet 8 Is under Care Coordination (2016)

Provider Standards: IHH

Enhanced Access

- Assurance of enhanced member and member caregiver (in the case of a child) access, including coverage 24 hours per day, 7 days per week
- Use of email, text messaging, patient portals and other technology to communicate with members is encouraged

Bullet 1: Health Information Technology aligning with CCHH

Provider Standards: IHH

Emphasis on Quality and Safety

- An ongoing quality improvement plan to address gaps and opportunities for improvement (within 12 months removed)
- Participate in ongoing process improvement on clinical indicators and overall cost effectiveness specified by and reported to the State
- Demonstrate continuing development of fundamental Health Home functionality through an assessment process to be applied by the State.
- Have strong, engaged organizational leadership who are personally committed to and capable of:
  - Leading the practice through the transformation process and sustaining transformed practice
  - Agreeing to participate in learning activities including in person sessions, webinars, and regularly scheduled phone calls
  - Agree to participate in or convene ad hoc or scheduled meetings to plan and discuss implementation of goals and objectives for practice transformation with ongoing consideration of the unique practice needs for adult members with SMI and child members with SED and their families

Provider Standards: IHH

- Participate in CMS and State required evaluation activities
- Submit reports as required by the State (e.g., describe IHH activities, efforts, and progress in implementing IHH services)
- Maintain compliance with all of the terms and conditions as an IHH provider
- Commit to the use of an interoperable patient registry and certified Electronic Health Record (EHR) within a timeline approved by the Lead Entity or IME, to input information such as annual metabolic screening results, and clinical information to track and measure care of members, automate care reminders, and produce exception reports for care planning
- Complete web-based member enrollment, disenrollment, members' consent to release to information, and health risk questionnaires for all members
- Demonstrate use of a certified EHR to support clinical decision making within the practice workflow.
- Demonstrate evidence of acquisition, installation, and adoption of an EHR system and establish a plan to meaningfully use health information in accordance with the federal law
- Implement state required disease management programs based on population-specific disease burdens. Individual Health Homes may choose to identify and operate additional disease management programs at any time

Bullet 1, 2, & 3 Aligning with CCHH

Payment Methodologies

Minimum Criteria To Bill

- The member meets the eligibility requirements for health home enrollment as identified in this SPA and documented in the members electronic health record (EHR)
- Member's eligibility requirements verified within the last 12 months. The member has full Medicaid benefits at the time the PMPM payment is made
- The member has enrolled with the IHH provider
- The Health Home Provider is in good standing with IME and is operating in adherence with all Health Home Provider Standards
- The minimum service required to merit a PMPM payment is that the person has received care management monitoring for treatment gaps defined as Health Home Services in this State Plan. The Health Home must document Health Home Services that were provided for the member.

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36

Bullet 1: Align with CCHH
Bullet 2: At a minimum, the care coordinator shall contact Intensive Care Management (ICM) members, who are those on the1915(i) Habilitation Program and1915(c) Children's Mental Health Waiver at least monthly either in person or by telephone with an interval of at least fourteen (14) calendar days between contacts. ICM members shall be visited in their residence or location of service face-to-face by their care coordinator as frequently as necessary but at least quarterly with an interval of at least sixty (60) days between visits for quarterly requirements. The location of service cannot be the IHH offices.

PMPM Additional Information

Minimum Criteria for Intensive Care Management (ICM) members that are enrolled in the 1915(i) Habilitation Program or the 1915(c) Children's Mental Health Waiver. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements: in accordance with 441 Iowa Administrative Code Chapter 90.

Claims analysis identified a total count of eligible Health Home Members. Using industry standards for staffing, clinical staffing ratios were determined. The development of the PMPM considers the marketplace value of professional staff to provide the six health home services.

The IHH is eligible to be reimbursed according to the member's tier for any month in which any of the six core services has been provided. Adults and children shall be grouped into four tiers:

- Tier 5 is an adult that qualifies for an IHH but without approved HCBS Habilitation Services
- Tier 6 is a child that qualifies for an IHH but without approved HCBS Children's Mental Health Waiver (CMHW)
- Tier 7 is a member with approved HCBS Habilitation Services
- Tier 8 is a child with approved for the HCBS CMHW

Bullet 1: Updated to align with Iowa Code and isn't the requirement for payment.
Bullet 2 & 3: This was updated to be additional payment for the work around managing the services vs the age of the member.

Rate Development

The payment rate may vary between adult and child and with or without the intensive care management (ICM).

The rate is developed according to the actual cost of providing each component of the service for the adult population with and without intensive care management and the child population with and without intensive care management service. No other payments for these services shall be made.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Health Home services. The agency's fee schedule rate was set as of January 1, 2022 and is effective for services provided on or after that date. All rates are published https://dhs.iowa.gov/ime/providers/csrp/fee-schedule For dates of service on or after January 1, 2022, the Agency fee schedule rates will be updated and posted at https://dhs.iowa.gov/ime/providers/csrp/fee-schedule

Salaries are pulled from Iowa Wage Report data (https://www.iowaworkforcedevelopment.gov/iowa-wage-report) using applicable codes for each individual role. Costs were allocated based on caseloads and enrollment, with budget neutrality.

The rates will be reviewed on an annual basis using the same methodology described in this section.

This section was not in the 2016 template.

How to bill

The Health Home will bill a 99490 with the appropriate modifier to identify the tier with the informational codes on subsequent line items to attest to Health Home Services Provided.

Procedure Code Health Home PMPM 99490

Tier/Modifier

- 5 (Adult) TF
- 6 (Child) TG
- 7 (HAB ICM) U1
- 8 (CMH ICM) U2

Informational Only Codes

Health Home/Service Code

- Comprehensive Care Management G0506
- Care Coordination G9008
- Health Promotion 99439
- Comprehensive Transitional Care 99426
- Individual &Family Support Services H0038
- Referral to Community and Social Support Services S0281

This was not in the 2016 SPA

The only change was tier 7/8 and the Informational codes

Avoiding Duplication of Payment

To avoid duplication of services, members who are enrolled in the 1915i Habilitation program and concurrently enrolled in a 1915c waiver program, will receive their coordination of services through the Community-Based Case Manager. Members may choose to be enrolled with the Integrated Health Home at a tier 5 or 6. The CBCM and Integrated Health Home will work together to ensure non-duplication of services. Additionally, Lead Entities are contractually required to ensure non-duplication of payment for similar services. The State reviews and approves Lead Entity nonduplication strategies and conducts ongoing monitoring to assure continued compliance.

If the individual is already enrolled in a Health Home for members with chronic conditions, the member must choose between the Chronic Condition Health Home (CCHH) and the IHH. A member cannot be in more than one Health Home at the same time. Members in the IHH will have state plan services coordinated through the Integrated Health Home Provider. If a member receives case management through a waiver to the State Plan and also qualifies for the Integrated Health Home, the Health Home must collaborate with the Community-Based Case Manager (CBCM), and Service Coordinators to ensure the care plan is complete and not duplicative between the two entities at a minimum of at least quarterly.

If a member receives Case Management through a waiver to the State Plan and also qualifies for the SPMI Health Home, the member can choose between the SPMI Health Home or the Targeted Case Management Service provided through the waiver.

Health Homes Services

Comprehensive Care Management

Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty healthcare, and community support services, using comprehensive person-centered care plan that addresses all clinical and non-clinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

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42

Added a definition to each Health Home Service for clarity. This verbiage is based on the IG_Health_Homes Document.

Comprehensive Care Management

- Outreach and engagement activities to members to gather information and engage in comprehensive care management
- Assessment of the member's current and historical information provided by the member, the Lead Entity, and other health care providers that supports the member
- Assessment includes a physical and behavioral assessment, medication reconciliation, functional limitations, and appropriate screenings, completed by a licensed health care professional within 30 days of enrolling
- Assess the member's social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors
- Assessing member's readiness for self-management using screenings and assessments with standardized tools
- Comprehensive Assessment is conducted at least every 12 months or more frequently as needed when the member's needs or circumstances change significantly or at the request of the member or member's support
- Creation of a person-centered care plans by a licensed health care professional with the member and individuals chosen by the member that address the needs of the whole person with input from the interdisciplinary team and other key providers

Department of HUMAN SERVICES

43

Bullet 1, 2, 3: IG Health Homes Language. Because this document requires an assessment that aligns with Federal requirements around a Person-centered Service Plan [42 CFR § 441.725 - Person-centered service plan. | CFR | US Law | LII / Legal Information Institute (cornell.edu)](), One would have to assess these first to be able to incorporate the information into the Plan.
Bullet 4: I wanted to clarify using readiness rulers and Motivational Interviewing.
Bullet 5, 6: IG Health Homes Language
Bullet 7: Was under Health Promotion (2016)
Bullet 8: IG Health Homes Language (Care Coordination)

Comprehensive Care Management

- Organize, authorize, and administer joint treatment planning with local providers, members, families, and other social supports to address total health needs of members
- Wraparound planning process: identification, development and implementation of strengths-based individualized person-centered care plans addressing the needs of the whole child and family
- At least monthly reporting of member gaps in care and predicted risks based on medical and behavioral claims data matched to Standard of Care Guidelines
- Information technology functionality developed to allow online receipt of standardized Continuity of Care Document (CCD)
- Continuous claims-based monitoring of care to ensure evidence-based guidelines are being addressed with members /families
- Serve as communication hub facilitating the timely sharing of information across providers 24 hours/day, 7 days/week
- Serve as active team member, monitoring and intervening on progress of member treatment goals using holistic clinical expertise
- Assignment of team roles and responsibilities

Comprehensive Care Management (HIT)

The Lead Entity will provide technology support for comprehensive care management. MCO technology support functions are reviewed and approved by the State. Examples of technology support functions which may be employed by Lead Entities, subject to State review and approval include, but are not limited to the following:

- A secure portal with program and member level information
- An enrollment feature with status and authorization release forms
- Predictive modeling and reporting tool to identify the population at risk including risks for hospital admission, gaps in care, and other claims-based data
- Assessment-driven whole person member profile development provided to inform local IHH provider
- Administration of online provider tools, including Health and Wellness Questionnaire to assess initial risk level, and Care Coordination Plan Member profile summarizing key information about the members medications, healthcare services, recent claims, and gaps in care
- Ability to exchange and display continuity of care documents sourced from providers' electronic health records to facilitate timely sharing of clinical information among treating providers
- A data warehouse for ongoing monitoring and analysis of program activity, provider engagement, and outcomes
- Regular report distribution to the local IHH Provider teams
- A member website

Department of HUMAN SERVICES

45

Bullet 1: Combined several bullets (2016)

Comprehensive Care Management (Team)

- Nurse Care Managers from the IHH will be responsible for the oversight of this service
- Care Coordinators may assist the Nurse Care Manager in the delivery of this service
- Peer Support Specialist or Family Support Specialist may assist with the development of and contribute information to support the Comprehensive Assessment and Person-Centered Care Plan
- Lead Entity
  - Participate in joint treatment planning with local providers, members, families, and other social supports to address total health needs of members as needed

Department of HUMAN SERVICES

2016 had MD/DO (psychiatrist)

Nurse Care Managers from the Lead Entity or the IHH providers. Nurse Case Managers from the Lead Entity or the IHH will be responsible for the delivery of this service

Care Coordination

Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, and transition of care, wellness education, health support and/or lifestyle modification, and behavior changes. Coordinate, direct, and ensure results are communicated back to the IHH.

I believe this was taken from another SPA

Care Coordination

- Implementation of a Person-Centered Care Plan
- Outreach activities to members to engage in care coordination
- Continuous monitoring of progress towards goals identified in the person-centered care plan though face-to-face and collateral contacts with member, member's supports, primary care, and specialty care
- Scheduling appointments
- Making referrals
- Tracking referrals and appointments
- Follow-up monitoring
- Communicating with providers on interventions/goals
- Conducting joint treatment staffing: meeting with multidisciplinary treatment team and member/parent/guardian to plan for treatment and coordination
- Support coordination of care with primary care providers and specialists
- Addressing barriers to treatment plan
- Coordinate multiple systems for children with SED as part of a child and family-driven team process
- Appropriately arrange care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care

Bullet 1, 2: IG Health Homes Language
Bullet 3, 4, 6: Other SPAs

Care Coordination (HIT)

- The Lead Entity will provide a secure portal to assist the IHH to coordinate care.
- The establishment of an EHR system will assist care coordinators with maintaining a comprehensive medication list, allow providers access to evidenced-based decisions and assist with referral protocols.
- Health IT can assist care coordinators providing and disseminating wellness education, informative tracks, and resources that supports lifestyle modification and behavior changes.

HIT needed to have more detailed information.

Care Coordination (Team)

- Nurse Care Managers will be responsible for the oversight of this service.
- Care Coordinators may assist the Nurse Care Manager with the delivery of this service
- Peer Support Specialist or Family Support Specialist may assist with the following Care Coordination services:
  - Outreach
  - Follow-up monitoring
  - Assist the member to schedule appointments
  - Attending joint staffing treatment meetings
  - Support coordination of care with providers and specialist
- The Lead Entity assists the IHH in performing care coordination.
  - MD/DO and Psychiatrists at the Lead Entity may also support Care Coordination activities by attending joint treatment meetings and provide consultation as needed

Department of HUMAN SERVICES

50

Nurse Care Coordinators at the IHH or the Lead Entity will perform Care Coordination. MD/DO and Psychiatrists at the Lead Entity may also support Care Coordination activities by attending joint treatment meetings and provide consultation as needed.

Peer Support or Family Support Specialist, may assist with the following Care Coordination services: Follow-up Monitoring, Scheduling Appointments, Attending joint staffing treatment meetings, support coordination of care with Providers and specialist.

Next Steps

- Finish review of Health Home SPA
- Survey and Listening Sessions Report
- Iowa Administrative Code Review